Grant Application
Medical Health Assessment Questionnaire
To be completed by a Health Care Professional

This medical health questionnaire is used to determine the applicant eligibility, medical information must be provided for the applicant in order to be considered for the grant. It is essential for the grant committee to have the current health information, in order to be able to assess the degree of severity of the individual's health condition as a criteria for eligibility. This form should be completed by the applicant's physician and should be uploaded with the application for the MyGOAL grant.

Patient's Last Name:_____ Patient's First Name:_____

D.O.B. _____ Gender:_____

Address:_____ City_____ Zip Code:_____

To Be completed by Health Care Professional:

Please provide information regarding the severity of the Autism diagnosis of the patient:
Age at diagnosis _____

Current level of functionality _____

Verbal ability_____

Current Level of social engagement _____

Degree of Behaviors _____

What level of supports/supervision does the patient require?: (Please describe)
Minimal_____
Moderate_____
Maximal_____

Describe other health conditions the patient has (ie seizure, asthma, etc)_____
_____

Special considerations/Precautions _____

Physician Name:_____ Physician Signature:_____

Name of the Practice:_____ Date:_____

Address:_____City:_____State:_____Zipcode:_____

Phone Number:_____ Email:_____

Caregiver/Guardian Signature:_____ Date:_____